Eliminating Racial and Ethnic Health Disparities in the Military Health System

Michael-Anne Browne, MD
Chair, Health Systems Subcommittee
March 22, 2023

Overview

- Membership
- Tasking
- Background
- Objectives and Scope
- Summary of Subcommittee Activities to Date
- Findings & Recommendations
- Way Ahead

Membership

CHAIR
Michael-Anne Browne, MD*

Maria Caban Alizondo, PhD, MA*

David Classen, MD

Robert Kaplan, PhD, MS

Catherine McCann, PhD, MS

Rhonda Medows, MD*

Jayakanth Srinivasan, PhD, MS

***Board Member**

Tasking

On May 12, 2022, the Assistant Secretary of Defense for Health Affairs directed the Defense Health Board ("the Board") to **provide recommendations to address racial and ethnic health disparities within the Military Health System (MHS).**

Background

- 31% of Active Duty personnel self-identify as a racial minority
- 16% of Active Duty personnel self-identify with Hispanic ethnicity
- Many MHS studies demonstrate narrowing, or even elimination, of disparate health outcomes across race and ethnicity over a wide range of conditions and age groups
- Physical and mental health inequities persist despite the MHS universal health care benefit

Objectives and Scope

- Review the existing literature on disparities in health outcomes of Active Duty Service members and other MHS beneficiaries by race and ethnicity. Compare those disparities to those experienced in other U.S. health care systems.

- Identify systemic barriers to eliminating racial and ethnic health outcome disparities within the MHS, considering policy, processes, staffing, and training.

- Provide recommendations to address health disparities by race and ethnicity within the MHS.

Summary of Activities to Date (1/2)

Meeting Date	Discussion Topics
Mar 30, 2022: DHB Meeting	Racial and Ethnic Health Disparities in the MHS
Jun 28, 2022: HS Subcommittee Kickoff Meeting	• Expansion on racial and ethnic health disparities in the MHS • Improving Health Equity via Recruiting, Retention and Education at Uniformed Services University of the Health Sciences
Jul 27, 2022: HS Meeting	• MHS Data Systems and Race/Ethnicity Data • Addressing Racial and Ethnic Health Disparities in the U.S.
Aug 10, 2022: DHB Meeting	• Update of report to DHB members • Veterans Health Administration efforts to promote health equity
Aug 24, 2022: HS Meeting	• Health outcome disparities in the MHS • Efforts to address health disparities at Naval Medical Center Portsmouth
Sep 28, 2022: HS Meeting	DoD Inspector General advisory on non-compliant race coding values in the MHS Data Repository
Oct 26, 2022: HS Meeting	• NPIC and NSQIP reporting on MHS race and ethnicity data • Racial and ethnic disparities in maternal health research and recommendations

Summary of Activities to Date (2/2)

Meeting Date	Discussion Topics
Nov 30, 2022: DHB Meeting	• Report update to DHB members: Emerging themes • Data collection and availability issues
Dec 5, 2022: HS Meeting	Mental Health Disparities Research: • Psychiatric Conditions During Pregnancy and Postpartum • Minority Adolescent Mental Health Diagnosis Differences
Jan – Feb 2023: Informational Teleconferences	Institute for Healthcare Improvement; Rush University; Kaiser Permanente; Boston University; Providence
Jan 19, 2023: HS Meeting	• Mayo Clinic Health Equity Initiatives • Potential Recommendations
Feb 16, 2023: HS Meeting	• Overview of informational teleconferences • Report Development: Outline and Recommendations
Mar 2, 2023: Visit to Naval Medical Center San Diego	NMCSD initiatives to identify and address racial and ethnic health outcome disparities
Mar 16, 2023: HS Meeting	Report Development: Outline, Recommendations, and Background

Naval Medical Center San Diego

- Basic clinical operations (GENESIS implementation, low overall staffing, no dedicated time/FTE) keep personnel from fully pursuing initiatives like quality improvement, research, and health equity
- Reinforced impression that health equity initiatives in the MHS originate from the bottom-up through extraordinary efforts of passioned individuals working on the topic outside of normal work hours
- DEERS overrides EHR race and ethnicity fields
- Practical realities lead front desk staff to accept “Other” or “Unknown” entries imported from DEERS, and to not verify that current entries are correct [originally took 5 minutes to check-in, now down to 2+ minutes]
- Translation services – and ease of access and use – play a part in overcoming barriers that lead to health disparities

Emerging Findings & Draft Recommendations
(1/10)

Emerging Finding
1. Insufficient analysis of explanatory variables - such as socioeconomic status (approximated as rank in the MHS), geographic location (e.g., urban/rural), or primary language - that may correlate with race and ethnicity limit the interpretation and response to research findings of racial and ethnic health outcome disparities in the MHS.
Draft Recommendation
1. DHA and Uniformed Services University, through their research funding, research oversight, and Institutional Review Boards, should ensure that the design of DoD-conducted and DoD-funded research on MHS racial or ethnic health outcome disparities include socioeconomic status (or surrogates thereof), a measure of regional health services availability, and primary language as explanatory variables.

Emerging Findings & Draft Recommendations
(2/10)

Emerging Finding
2. MHS data systems do not fully capture race and ethnicity data to fully describe the beneficiary population. Most MHS family member beneficiaries either have an incorrect or missing value for race and ethnicity in MHS data systems or have their race and ethnicity inferred from their active-duty family member in disparities research. The MHS GENESIS source for race and ethnicity data is the Defense Enrollment Eligibility Reporting System (DEERS). On January 1, 2023, the Joint Commission's requirement for hospitals and other health care programs to collect race and ethnicity for all patients took effect. The Joint Commission encourages organizations to use the five race and two ethnicity categories from the Office of Management and Budget (OMB), at a minimum.

Emerging Findings & Draft Recommendations

(2/10 continued)

Draft Recommendations

2. A: DoD should collect self-identified race and ethnicity data for all beneficiaries – and not just active-duty Service members – through DEERS. Harmonize all race and ethnicity data between all administrative data sources.

2. B: Empower patients to view, self-identify, and update race and ethnicity in DEERS.

2. C: DoD should continue to conform with the OMB Federal Minimum Standards for Race and Ethnicity. We further recommend DEERS eliminate its current "Other" and "Unknown" categories and replace these with "Multicultural."

2. D: Check-in staff should be encouraged to review patients' listed race and ethnicity and assist the patient with any needed changes. Local staff at MTFs needs read-access to DEERS and ability to notify DEERS when changes are needed. Audit requests to ensure changes were made.

Emerging Findings & Draft Recommendations
(3/10)

Emerging Finding
3. Most of the literature on MHS health equity/disparities derives from individual-initiated, one-time data pulls, or local Quality Improvement projects and are neither sustained nor system-wide efforts. The MHS' and DHA's centralized outcomes tracking – internally and through external reporting in national registries – does not include racial and ethnicity stratification and/or make such analyses easy to access.

Emerging Findings & Draft Recommendations
(3/10 continued)

Draft Recommendations

3. A: DHA and the MHS should add race and ethnicity to their existing standardized process for continuous quality management in the measurement, monitoring, and visualization of its health and safety outcomes. Incorporate race and ethnicity into daily operational and leadership reports. All quality reporting (Joint Commission, NCQA, HEDIS, etc.) should include racial and ethnic stratification of results.

3. B: MHS should identify and designate dedicated staff to do this work. A centralized group of statisticians should conduct the analysis of aggregated datasets, identify disparities, and communicate their findings.

3. C: Design of initiatives and countermeasures to improve overall health outcomes should incorporate specific interventions to reduce and eliminate existing disparities – by race, ethnicity, region, sponsor rank, or other factors.

3. D: Work with national registries such as NPIC and NSQIP to allow MHS systemwide race and ethnicity reporting. This will help to inform actions to decrease the variation in outcomes between facilities overall.

Emerging Findings & Draft Recommendations
(4/10)

Emerging Finding
4. When selecting clinical areas for improvement efforts it is preferable to target areas with the most likely impact.

Draft Recommendations
4. A: We suggest the following priorities be used when selecting initial clinical areas of improvement with most likely impact on disparities: • Clinical conditions that affect a large population • Clinical conditions that affect large number of person life-years lost • Clinical areas of known racial or ethnic disparity • Clinical conditions that impact readiness of the force 4. B: Prioritize these health conditions where preliminary evidence suggests the existence of disparities by race: • Cardiovascular (hypertension, heart disease, diabetes) • Obstetrics (maternal and infant health) • Pediatrics (vaccination, well-child visits, obesity) • Oncology (screening and outcomes) • Mental health (access and outcomes)

Emerging Findings & Draft Recommendations
(5/10)

Emerging Finding
5. Some medical risk calculators, decision-making tools, and equipment in use by MHS health care personnel introduce racial and ethnic bias.
Draft Recommendation
5. Create a centralized mechanism to review new protocols and equipment to prevent incorporation of racial bias into MHS clinical practice, and replace or eliminate existing race-biased tools, protocols, AI, Machine Learning algorithms, and equipment with the best-performing race-agnostic alternatives.

Emerging Findings & Draft Recommendations
(6/10)

Emerging Finding
6. There is limited data on the direct impact of Diversity, Equity, Inclusion, and Accessibility (DEIA) training initiatives on health outcomes. Some DEIA training methods promote empathy and reduce bias which can influence health outcomes.
Draft Recommendation
6. Carefully consider the qualities of any DEIA training before implementing it. Measure the training's impact on patient experience and other measures. Select vendors that have a proven record of delivering effective DEIA training programs.

Emerging Findings & Draft Recommendations
(7/10)

Emerging Finding

7. Increased clinician-patient race and ethnicity concordance results in improved patient care experiences through better communication, greater cultural competency, and reduced inadvertent implicit bias. The US Government has committed to expanding ROTC programs to Historically Black Colleges and Universities (HBCU) with STEM programs and without ROTC programs as a pathway to more under-represented minorities in the Armed Services. Almost half of HBCUs with nursing programs do not have an affiliation with a ROTC program.

Draft Recommendations

7. A: Add the presence of nursing, pre-medical, and other pre-health career curricula to criteria for HBCU ROTC program expansion.

7. B: Promote workforce diversity through recruitment activities focused on underrepresented in medicine affinity academic organizations.

7. C: Assess intervention effectiveness by a range of stratifications including location and clinical service type.

Emerging Findings & Draft Recommendations
(8/10)

Emerging Finding
8. Evidence shows that clinical care affects only approximately 20% of variation of health outcomes while as much as 50% of variation in health outcomes come from Social Determinants of Health (SDOH).

Draft Recommendations
8. A: Expand SDOH screenings of MHS beneficiaries throughout the life course by integrating annual standardized SDOH screening tools and workflows in MHS GENESIS particularly in primary care, pediatrics, and obstetrics.
8. B: Proactively analyze results of SDOH screenings and promote resources and interventions to address the needs of MHS beneficiaries.
8. C: Promote culturally appropriate health literacy initiatives designed for specific audiences at each location based on health outcomes data, community input, and best practice health messaging.

Reference: US Department of Health and Human Services, 2022

Emerging Findings & Draft Recommendations
(9/10)

Emerging Finding
9. All virtual visits in REVCYCLE require entering the patient's preferred language, but not for in-person visits, leaving staff to spend time during the appointment to connect to interpretation services or serving as interpreters themselves. Language barriers play a role in patient experience which contributes to variation in health outcomes.
Draft Recommendation
9. Make patient's preferred language a required field when making in-person appointments and ensure appropriate interpretation services are available for all visits.

Emerging Findings & Draft Recommendations
(10/10)

Emerging Finding
10. Medical and dental readiness reports for DoD leadership do not currently provide health information stratified by race and ethnicity.
Draft Recommendations
10. A: Regularly include race and ethnicity in readiness reports. 10. B: Hold leaders accountable for addressing racial and ethnic disparities in medical readiness. Require the Command at individual MTFs to work with operational unit Commands to address and reduce racial and ethnic medical readiness disparities.

Way Ahead

- Report development meetings:
  - April 12, 2023
  - April 26, 2023
  - May 10, 2023
  - May 24, 2023
- Anticipated pre-decisional draft delivery to DHB: June 14, 2023
- DHB deliberation: June 28, 2023

Questions